



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax (972) 827-3707

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 9/3/12

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a right shoulder arthroscopy.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☐ Upheld (Agree)
☒ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a right shoulder arthroscopy.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed: 8/17/12 letter 8/16/12 misaddressed letter ODG section regarding SLAP lesions, 5/23/12 denial letter, and 5/18/12 denial letter.

8/15/12 summary letter 4/30/12 diagnosis sheet,
2/15/12 right shoulder MRI report, 11/21/11 to 1/11/12 reports
3/16/12 to 4/12/12 doctor reports
4/26/12 to 6/7/12 physical activities log, and 10/12/11 to
10/24/11 office notes.

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

In the most recent AP records, there is an appeal letter. It states that the claimant has had persistent shoulder pain, especially with overhead lifting. Examination reveals tenderness and positive impingement signs at the right shoulder, along with weakness. The 2/15/12 dated right shoulder MRI revealed an extensive labral tear along with cuff tendinosis and AC joint arthrosis. The AP's patient's records were all reviewed, with evidence of treatment trial and failures with medications, injection and PT. Records from a documented C6 radiculopathy and carpal tunnel syndrome. Records from were also reviewed. The injury mechanism was noted to involve repetitive lifting of approximately 200 cans while working. XXX records were reviewed, also documenting neck and back pain. Denial letters discussed a prior failure to exhaust non-operative treatments.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The patient has now been reasonably documented to have failed conservative treatments of medications, therapy, restricted activities and cortisone injections. With both positive subjective and objective findings that correlate with the MRI abnormalities, applicable ODG criteria have been met and the requested procedure is medically reasonable and necessary at this time per the ODG Shoulder Chapter regarding surgery for SLAP lesions.

Recommended for Type II lesions, and for Type IV lesions if more than 50% of the tendon is involved. See SLAP lesion diagnosis. The advent of shoulder arthroscopy, as well as our improved understanding of shoulder anatomy and biomechanics, has led to the identification of previously undiagnosed lesions involving the superior labrum and biceps tendon anchor. Although the history and physical examinations as well as improved imaging modalities (arthro-MRI, arthro-CT) are extremely important in understanding the pathology, the definitive diagnosis of superior labrum anterior to posterior (SLAP) lesions is accomplished through diagnostic arthroscopy. Treatment of these lesions is directed according to the type of SLAP lesion. Generally, type I and type III lesions did not need any treatment or are debrided, whereas type II and many type IV lesions are repaired. Shoulder surgery for SLAP tears may not be successful for many patients. For example, of pitchers who failed physical rehabilitation and then went on to surgery just 7% were able to play as well as they had before, but for pitchers who just underwent physical rehabilitation, 22% were able to play as well as they previously had.

Surgery for Impingement Syndrome

ODG Indications for Surgery -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS
2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees.

AND Pain at night. PLUS

3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS

4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

